TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROPOLITAN METHODIST

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M-18-0411-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
October 16, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are in receipt of a denial for the above mentioned claim by SORM for Timely Filing. We are requesting that you request that they reprocess this claim with the following proof showing that he claim was submitted to SORM timely . . ."

Amount in Dispute: $57,544.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office respectfully requests the Division to dismiss this dispute due to the requestor failing to file this request for medical dispute within 1 year from date of service pursuant to Rule §133.307 (c) (1) (A)."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2016	Outpatient Hospital Services	$57,544.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 937 – SERVICES(S) ARE DENIED BASED ON HB7 PROVIDER TIMELY FILING REQUIREMENT. A PROVIDER MUST SUBMIT A MEDICAL BILL TO THE INSURANCE CARRIER ON OR BEFORE THE 95TH DAY AFTER THE DATE OF SERVICE.
   - 167 – THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Did the insurance carrier make additional payment after appeal or reconsideration of the disputed bill?
2. Are the insurance carrier's reasons for denial supported?
3. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The insurance carrier reduced or denied disputed services with claim adjustment reason code: W3 – "ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION." No documentation was presented of additional payment made after appeal or reconsideration. No evidence was found to support the insurance carrier paid anything at all. This claim adjustment reason code is not supported.

2. Additionally, the insurance carrier denied disputed services with claim adjustment codes: 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED" and 937 – "SERVICES(S) ARE DENIED BASED ON HB7 PROVIDER TIMELY FILING REQUIREMENT. A PROVIDER MUST SUBMIT A MEDICAL BILL TO THE INSURANCE CARRIER ON OR BEFORE THE 95TH DAY AFTER THE DATE OF SERVICE."

   28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   Texas Labor Code §408.0272(b) provides that, notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

   (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
      (A) an insurer that issues a policy of group accident and health insurance . . .
      (B) a health maintenance organization that issues an evidence of coverage . . .
      (C) a workers' compensation insurance carrier other than the insurance carrier liable . . .
   (2) the commissioner determines that the failure resulted from a catastrophic event . . .

   Texas Labor Code §408.0272(c) further requires that, notwithstanding §408.0272(b), a provider who erroneously submits a claim for payment to an entity described above:

   > forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim.

   The requestor presented proof satisfactory to the division that the provider, within the initial 95 day period, filed the medical bill for reimbursement with an erroneous carrier, and that after initially paying the bill, that carrier requested a refund directing the provider to bill the workers' compensation carrier, SORM. The documentation is sufficient to support an exception to the timely filing requirements under Labor Code §408.0272(b)(1).

   For that reason, the health care provider was required to submit the medical bill not later than 95 days from the date the provider was notified of the erroneous submission of the claim, in accordance with the requirements of Labor Code §408.0272(c). Review of the submitted information finds the health care provider timely presented the bill the workers' compensation carrier, SORM, within the requirements of Labor Code §408.0272(c).

   As the bill was timely submitted to the carrier, the insurance carrier's denial reasons are not supported.

3. 28 Texas Administrative Code §133.307(c)(1) requires that:

   > A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is April 18, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 16, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	November 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	November 10, 2017
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.